ACCESSTN
COVER TENNESSEE

Winter 2007
Application Instruction Booklet
Benefit Plans & Premium Tables

How do I apply?

Fill in the AccessTN application that came with this booklet. Call 1-866-636-0080 toll free if you have questions or need help with the application. Make sure it is complete and sign it. If you are applying for premium assistance, you must also include the separate premium assistance application. These forms are also available on the web at www.AccessTN.gov if you need more.

Information on the health plans offered and how to figure your premium is in this booklet. You do not have to send a check or money for your premium with this application. But figure your premium to make sure it is an amount you can afford each month, along with your deductible and co-insurance.

We will begin processing applications March 1, 2007 for eligibility. Any applications received before that date will be treated as being received on March 1, 2007. Any application after that date will be processed in order of the date we receive it. Remember that incomplete applications will be returned.

You do not need to return this booklet with your application. But use the checklist on the back of the application to make sure you have sent everything required. Send your application and other papers as soon as you can. And we strongly suggest you make a copy of what you send us to keep for yourself.

If we receive more applications as of March 1, 2007 than there are places available in AccessTN, we will process the applications according to a random selection process. This selection will be designed to give each person in the same grouping an equal chance for a place in the program. If we receive more applications than there are places available, we will place additional people on a waiting list for coverage as spaces open up. Some but not all of the spaces have been reserved during the first 60 days for applicants disenrolled from TennCare after July 2005.

Inside is some information that we hope will help you fill out the application. It is arranged by sections in the same order as in the application. But remember –

Call 1-866-636-0080 toll free if you have questions or need help with the application.
Our mailing address for completed applications is:

AccessTN
c/o BlueCross BlueShield of Tennessee, Inc.
801 Pine Street
Chattanooga TN 37402

AccessTN is a program of the State of Tennessee. The health plans are administered by
BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

Form ACTN-004 (02/07) This booklet not for use after April 30, 2007.

AccessTN Health Insurance Coverage
State of Tennessee • Department of Finance and Administration

Return applications to:
BCBST, 801 Pine Street, Chattanooga TN 37402
AccessTN is administered by BlueCrossBlueShield of Tennessee, Inc., an Independent Licensee of the BlueCrossBlueShield Association

Application Instructions

What is AccessTN?

AccessTN is a health insurance program sponsored by the State of Tennessee for people who can't get other coverage because of their medical conditions. When we say "coverage," we mean health insurance. We'll use "Plan" as short for AccessTN, including those companies we use to administer services such as enrollment, claims payment, or premium assistance.

In these and other Plan papers, we'll use plural words like "we" or "our" or "us" to mean AccessTN. We'll use individual words like "you" or "I" for the applicant, a person applying for coverage. We may also use "member" to refer to a person enrolled in AccessTN. When we say "health facts," we mean personal health information – your health history and other facts that identify you like your name and date of birth.

Anytime we say that something is available at www.AccessTN.gov, you can also get that information by calling toll free to 1-866-636-0080, which is the customer service line for the AccessTN plan administrator, BlueCross BlueShield of Tennessee, Inc. Information is available on their website at bcbst.com. You can find AccessTN information under the Plan Options tab at the top of the page.

What is insurance?

AccessTN is insurance. Insurance is a term we will emphasize. First, it is NOT TennCare, a medical assistance program regulated by federal Medicaid guidelines. It is not Medicare either.

Insurance is a contract arrangement in which you pay a set fee (a premium) to receive coverage for a set schedule of medical and health services (benefit plan). The premium is based on the Plan's professional estimate of what those services will cost. "Covered services" are simply those the Plan covers, or pays for. Please take some time to review page 4 showing the different options in benefit plans – Plans 1000, 2500, and 5000.

You should also understand that insurance will not pay for other services, called "non-covered services." If you have these services done, you will have to pay these claims yourself, even if a doctor prescribes them. That's why it's important to choose your benefit plan carefully and know what services we will and will not cover.

Who pays for AccessTN?

Our members may have serious health conditions and tend to have more medical claims. Our premiums are higher than commercial rates but still may not cover actual Plan costs. State funds and contributions from other health plans in the state will help pay part of the losses of AccessTN. State funds have also been provided to help members with premium payments, based on income.

We will enroll only the number we think the Plan can pay for. We look forward to providing AccessTN coverage. We are part of the Cover Tennessee family of state programs to help Tennesseans improve their access to health insurance and to medical care.

Section 1: Applicant Information

We need information about you to know how to contact you and to confirm that you qualify for the program. We realize this is your personal health information (PHI) and must be handled carefully. Some call this your "health facts" but it also includes other information that identifies you, like your date of birth, or street address. We and those companies that provide AccessTN services will only use it as state laws and privacy rules permit.

More information about how we will use your information is in Sections 8 and 9 of the application. Please read those sections carefully when you sign the form.

Section 2: What are the benefit plan options?

AccessTN has three different benefit plans, with the Plan name based on its "deductible." A deductible is the dollar amount of covered services you pay for before the Plan begins paying. Page 4 shows a general listing of services for each. More detailed information on covered services, their limits, and exceptions is in the Plan Document. All benefit plans are subject to change by the AccessTN Board.

- Plan 1000 has a $1000 deductible and, after premiums, requires you to pay the least amount of dollars out-of-pocket before the Plan starts paying 100% of most services. It is also the only benefit plan offering premium assistance, if you qualify.
- Plan 2500 has a $2500 deductible and is the only plan eligible for use with a health savings account (HSA). There's more information on HSAs below.
- Plan 5000 has a $5000 deductible. This is sometimes called "catastrophic" coverage for those who plan to pay most medical expenses on their own, but are looking for coverage for unexpected or unusually high medical expenses from a disease or injury.

Our current options are all based on a PPO (preferred provider organization) design. This means that the Plan contracts with a "network" of doctors, hospitals and other health providers. They agree to be paid a set amount for each covered service. They will not collect more from you than a pre-set share of the claim, called "co-insurance." This member share is frequently 20% in our benefit plans.

Services from "out-of-network" providers have a higher member share, frequently 40%. Those non-network providers can also charge you more than the Plan's "maximum allowed charge" (MAC). Look at the provider directory on bcbst.com or call 1-866-636-0080 to see if your current doctors are "in-network."

What is a health savings account?

A "health savings account" (HSA) is an individual account given special tax treatment to save for current and future medical expenses. HSAs have special rules and can only be used with a qualified high-deductible insurance plan. AccessTN will not offer the health savings account. We will offer the qualifying high deductible plan –- Plan 2500 – that allows you to enroll in an HSA. You can start the HSA at banks, credit unions, and insurers.

High-deductible plans for HSAs require you to pay out-of-pocket for the deductible plan without the exceptions permitted by Plans 1000 and 5000 for pharmacy, preventive care allowance and mental health counseling. See www.ustreas.gov or IRS Publication 969 for more information on HSAs.

AVAILABLE BENEFIT PLANS

Regular AccessTN category subject to 6 months pre-existing conditions waiting period, see rates page 6

TennCare Portability category not subject to any pre-existing conditions exclusion, see rates page 8

AccessTN OUTLINE OF PPO MEDICAL BENEFITS (see Plan Document for more detail)	**Plan 1000 "premium assistance-eligible"**	**Plan 2500 "health savings account-eligible"**	**Plan 5000 "catastrophic coverage"**
PREVENTIVE CARE ALLOWANCE	$300	$300	$300
This is first dollar coverage for wellness care such as an annual physical, before you have to pay any deductible or co-insurance.			
DEDUCTIBLE per plan year: In-network Out-of-network	$1,000 $2,000	$2,500 $2,500	$5,000 $10,000
Covered Expenses, as specified Plan Document , subject to maximum allowable charge (MAC)	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Prescription Drugs – subject to additional limitations Pharmacy not subject to deducible - Plans 1000 & 5000	No deductible for outpatient drugs	Deductible applies to drugs	No deductible for outpatient drugs
Generic Drugs	$10 co-pay (cost if less)	20 % co-insurance subject to deductible, and out-of-pocket limit;	$15 co-pay (cost if less)
Preferred Brand Drugs	25% co-insurance – min. of $25, max. of $50		30% co-insurance – min. of $30, max. of $75
Non-Preferred Brand Drugs	50% co-insurance –min. of $50, max. of $100	Non-preferred brands are <u>not</u> covered.	60% co-insurance - min. of $60, max. of $150
Maternity benefits	12 month waiting period	12 month waiting period	12 month waiting period
Chiropractic benefits	Subject to guidelines	Subject to guidelines	Subject to guidelines
Emergency services (in-network or out-of-network)	80% of reasonable charges	80% of reasonable charges	80% of reasonable charges
Emergency Room co-payment per visit – waived if admitted (Note: co-payment required even if out-of-pocket expenses have been met, except HSA)	$50 co-payment per visit in addition to co-insurance	subject to deductible and co-insurance requirements	$75 co-payment per visit in addition to co-insurance
Maximum Annual Out-of-Pocket Expense (does not apply to out-of-network services, co-pays for emergency room, or pharmacy – except for Plan 2500)	$5,000	$5,000	$10,000
Maximum Annual Benefits, except for organ transplant	$120,000	N/A	$100,000
Supplemental Organ Transplant benefit	$100,000	$100,000	$100,000
Maximum Lifetime Benefits - subject to prior benefits incurred in another state high risk pool(s)	$1,000,000	$1,000,000	$1,000,000
Maximum Annual Out-of-Pocket Expense	$5,000	$5,000	$10,000
Maximum Out-of-Pocket does not apply to pharmacy except for Plan 2500, to out-of-network services, or to co-pays for emergency room.			
Substance Abuse Treatment Limitations	Lifetime maximums: Two inpatient stays – maximum of 28 days per stay. Two inpatient stays for detoxification – maximum of 5 days per stay.		
ANNUAL LIMITS FOR SPECIFIC BENEFITS			
Pharmacy		$50,000 max	
Inpatient - non-emergent service must be preauthorized		45 days	
Inpatient Rehabilitation Facility		45 days	
Outpatient Rehabilitation Facility	45 days	45 days	45 days
Outpatient Physical Therapy, Occupational Therapy, Speech Therapy	45 sessions subject to Plan guidelines	45 sessions subject to Plan guidelines	45 sessions subject to Plan guidelines
Skilled Nursing Facility (Following approved hospitalization. Prior authorization required.)	45 days	45 days	45 days
Home Health Care	30 visits	30 visits	30 visits
Durable Medical Equipment	$3,000 Max	$3,000 Max	$3,000 Max
Inpatient Mental Health/ Substance Abuse	30 days	30 days	30 days
Outpatient Mental Health/ Substance Abuse	30 sessions	30 sessions	30 sessions

Benefit Plans subject to change by AccessTN Board. Plan reimbursement based on the maximum allowable charge (MAC). You will be responsible for the deductible and any applicable co-payment or co-insurance amounts. If non-network providers are used, you will also be responsible for payment of charges above the MAC.

Section 3: How do I figure my premium?

We will calculate your premium. Section 3 of the application does require you to provide some information about your weight and whether you smoke. AccessTN premiums provide a discount to those whose weight is at or below target weights listed in the table on the next page. And premiums are higher for those who smoke. It is a good idea to estimate what your premium will be. Pick a health benefit plan to fit your budget, including the premium, with the plan's deductible and co-insurance.

If you are not applying for premium assistance, pick the benefit plan (1000, 2500, or 5000) you are choosing for your eligibility category, and use that premium table for your premium. Premium tables for regular AccessTN begin on page 6 of these instructions or on page 8 for the TennCare Portability category. Then follow the instructions on those pages.

Section 4 has information on the difference between regular AccessTN and the TennCare Portability category. **Remember that people who were in TennCare may be eligible for either category**.

If you are applying for premium assistance for Plan 1000, go to premium assistance tables for regular AccessTN on page 7 of these instructions or on page 9 for the TennCare Portability category. Find the column that matches your household size and family income in the Income Guidelines table at the top of that page. Next, go to the bottom of that column to find the correct "__ % Level of Premium Assistance- Applicant Pays" table for your income and family size. Then follow the other steps listed on those pages to find your premium on that table.

What premium assistance is available?

If you have a family income of $60,000 or less, you can apply for help in paying your premiums. You should be prepared to pay your share of the premium each month. During the year, you will also need to pay your deductible and your portion of all claims, called co-insurance. The schedule of some of these expenses is on page 4 of this booklet.

Plan rules require that you tell us if you get help paying your share of the premium from anyone other than family and friends. But the rules allow a church or foundation to help if you let us know. Doctors, hospitals, or drug companies are not allowed to pay your share of the premium.

Anyone can help with costs other than premiums. Plan rules do not restrict who can help you with co-insurance, deductibles, or payments for services not covered by the Plan.

On the application, "Income" means money you have to pay federal taxes on, before taking standard and itemized deductions on your tax form. This income number includes wages, bonuses and other earnings. It includes interest, pensions, unemployment compensation, alimony you get, business income, or social security payments but does not include alimony you pay or supplemental security income (SSI) payments. If you use Form 1040 to pay taxes, the income number we use is at the top of page 2 (line 38**)** of your taxes**.** IRS calls it "Adjusted Gross Income" (AGI). We use IRS rules, which can be found at www.irs.gov.

"Family" or "Household" means you and all of your children at home or anyone you live with that the IRS lets you count as a dependent on yours or your spouse's tax return.

See information on premium assistance on page 7 of this booklet for regular AccessTN and on page 9 for the TennCare Portability category. For both eligibility categories, premium assistance is only available for Plan 1000.

Premiums for the regular AccessTN eligibility category

Plan 1000: $1,000 deductible

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco User	Tobacco User	Non Tobacco User	Tobacco User
<30	$387	$445	$430	$494
30-39	$450	$517	$500	$574
40-49	$546	$628	$607	$698
50-59	$649	$747	$722	$830
60-64	$766	$881	$851	$979
65+	$904	$1,040	$1,005	$1,156

Plan 2500: $2,500 deductible (HSA eligible)

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco User	Tobacco User	Non Tobacco User	Tobacco User
<30	$318	$366	$353	$406
30-39	$369	$425	$410	$472
40-49	$449	$516	$498	$573
50-59	$534	$614	$593	$682
60-64	$630	$724	$699	$804
65+	$743	$855	$826	$950

Plan 5000: $5,000 deductible

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco User	Tobacco User	Non Tobacco User	Tobacco User
<30	$273	$313	$303	$348
30-39	$317	$364	$352	$404
40-49	$384	$442	$427	$491
50-59	$457	$526	$508	$584
60-64	$539	$620	$599	$689
65+	$637	$732	$708	$814

Note-

1) All benefit plans above subject to 6 months pre-existing conditions waiting period and 12 month waiting period for maternity coverage.
2) You are eligible for AccessTN or TennCare Portability over the age of 64 ONLY if you are NOT eligible for Medicare.
3) AccessTN is not a Medicare supplement policy.

To determine your monthly premium, first find your height and weight on the chart below.

Next, go to the table for the benefit plan you have picked and find the row for your age group.

Then move across the row for your age to find the column that fits you:

- If your weight is equal to or less than what is listed in the chart, use the "Target Weight or Below" columns. If your weight is more than what is listed in the chart, use the "Above Target Weight" side.
- Finally, are you a tobacco user (cigarettes, chewing tobacco, pipe or cigars) or not?

This will be the monthly premium for your beginning coverage.

Defining Target Weight at BMI of 30	
Height	Target Weight
4' 10"	142
4' 11"	147
5' 0"	152
5' 1"	157
5' 2"	163
5' 3"	168
5' 4"	173
5' 5"	179
5' 6"	185
5' 7"	190
5' 8"	196
5' 9"	202
5' 10"	208
5' 11"	214
6' 0"	220
6' 1"	226
6' 2"	232
6' 3"	239
6' 4"	245
6' 5"	252

Premium assistance for regular AccessTN eligibility category
Plan 1000

Income Guidelines for Premium Assistance based on 2007 Federal Poverty Level

Persons in Household	Incomes up to 100% FPL	Incomes up to 150% FPL	Incomes up to 200% FPL	Incomes up to 250% FPL
1	$10,210	$15,315	$20,420	$25,525
2	$13,690	$20,535	$27,380	$34,225
3	$17,170	$25,755	$34,340	$42,925
4	$20,650	$30,975	$41,300	$51,625
5	$24,130	$36,195	$48,260	Up to $60,000
6	$27,610	$41,415	$55,220	Up to $60,000
7	$31,090	$46,635	Up to $60,000	Up to $60,000
8	$34,570	$51,855	Up to $60,000	Up to $60,000
Premium Assistance pays	75% of premium for non-tobacco, target weight or below	70% of premium for non-tobacco, target weight or below	50% of premium for non-tobacco, target weight or below	30% of premium for non-tobacco, target weight or below
Applicant Would Pay	According to table below for **75% Level of Premium Assistance**	According to table below for **70% Level of Premium Assistance**	According to table below for **50% Level of Premium Assistance**	According to table below for **30% Level of Premium Assistance**

75% Level of Premium Assistance - Applicant Pays

	Target Weight or Below		Above Target Weight	
Age	Non Tobacco User	Tobacco User	Non Tobacco User	Tobacco User
<30	$97	$155	$140	$204
30-39	$113	$180	$163	$237
40-49	$137	$219	$198	$289
50-59	$162	$260	$235	$343
60-64	$192	$307	$277	$405
65+	$226	$362	$327	$478

70% Level of Premium Assistance - Applicant Pays

	Target Weight or Below		Above Target Weight	
Age	Non Tobacco User	Tobacco User	Non Tobacco User	Tobacco User
<30	$116	$174	$159	$223
30-39	$135	$202	$185	$259
40-49	$164	$246	$225	$316
50-59	$195	$293	$268	$376
60-64	$230	$345	$315	$443
65+	$271	$407	$372	$523

50% Level of Premium Assistance - Applicant Pays

	Target Weight or Below		Above Target Weight	
Age	Non Tobacco User	Tobacco User	Non Tobacco User	Tobacco User
<30	$194	$252	$237	$301
30-39	$225	$292	$275	$349
40-49	$273	$355	$334	$425
50-59	$325	$423	$398	$506
60-64	$383	$498	$468	$596
65+	$452	$588	$553	$704

30% Level of Premium Assistance - Applicant Pays

	Target Weight or Below		Above Target Weight	
Age	Non Tobacco User	Tobacco User	Non Tobacco User	Tobacco User
<30	$271	$329	$314	$378
30-39	$315	$382	$365	$439
40-49	$382	$464	$443	$534
50-59	$454	$552	$527	$635
60-64	$536	$651	$621	$749
65+	$633	$769	$734	$885

Premiums for the TennCare Portability eligibility category

Plan 1000: $1,000 deductible

	Target Weight or Below		Above Target Weight	
Age	**Non Tobacco User**	**Tobacco User**	**Non Tobacco User**	**Tobacco User**
<30	$468	$539	$520	$598
30-39	$543	$624	$604	$695
40-49	$660	$759	$733	$843
50-59	$786	$904	$873	$1,004
60-64	$928	$1,067	$1,031	$1,185
65+	$1,094	$1,259	$1,216	$1,398

Plan 2500: $2,500 deductible (HSA eligible)

	Target Weight or Below		Above Target Weight	
Age	**Non Tobacco User**	**Tobacco User**	**Non Tobacco User**	**Tobacco User**
<30	$385	$443	$427	$491
30-39	$446	$513	$496	$571
40-49	$542	$624	$603	$693
50-59	$646	$743	$718	$825
60-64	$762	$877	$847	$974
65+	$899	$1,034	$999	$1,149

Plan 5000: $5,000 deductible

	Target Weight or Below		Above Target Weight	
Age	**Non Tobacco User**	**Tobacco User**	**Non Tobacco User**	**Tobacco User**
<30	$330	$379	$366	$421
30-39	$382	$440	$425	$489
40-49	$465	$534	$516	$593
50-59	$553	$636	$615	$707
60-64	$653	$751	$726	$835
65+	$771	$886	$856	$984

Note-

1) Benefit plans above are NOT subject pre-existing conditions waiting period but are subject to 12 month waiting period for maternity coverage.
2) You are eligible for AccessTN or TennCare Portability over the age of 64 ONLY if you are NOT eligible for Medicare.
3) AccessTN is not a Medicare supplement policy.

To determine your monthly premium, first find your height and weight on the chart below.

Next, go to the table for the benefit plan you have picked and find the row for your age group.

Then move across the row for your age to find the column that fits you:

- If your weight is equal to or less than what is listed in the chart, use the "Target Weight or Below" columns. If your weight is more than what is listed in the chart, use the "Above Target Weight" side.

- Finally, are you a tobacco user (cigarettes, chewing tobacco, pipe or cigars) or not?

This will be the monthly premium for your beginning coverage.

Defining Target Weight at BMI of 30	
Height	**Target Weight**
4' 10"	142
4' 11"	147
5' 0"	152
5' 1"	157
5' 2"	163
5' 3"	168
5' 4"	173
5' 5"	179
5' 6"	185
5' 7"	190
5' 8"	196
5' 9"	202
5' 10"	208
5' 11"	214
6' 0"	220
6' 1"	226
6' 2"	232
6' 3"	239
6' 4"	245
6' 5"	252

Premium Assistance the TennCare Portability eligibility category Plan 1000

Income Guidelines for Premium Assistance based on 2007 Federal Poverty Level

Persons in Household	Incomes up to 100% FPL	Incomes up to 150% FPL	Incomes up to 200% FPL	Incomes up to 250% FPL
1	$10,210	$15,315	$20,420	$25,525
2	$13,690	$20,535	$27,380	$34,225
3	$17,170	$25,755	$34,340	$42,925
4	$20,650	$30,975	$41,300	$51,625
5	$24,130	$36,195	$48,260	Up to $60,000
6	$27,610	$41,415	$55,220	Up to $60,000
7	$31,090	$46,635	Up to $60,000	Up to $60,000
8	$34,570	$51,855	Up to $60,000	Up to $60,000
Premium Assistance pays	75% of premium for non-tobacco, target weight or below	70% of premium for non-tobacco, target weight or below	50% of premium for non-tobacco, target weight or below	30% of premium for non-tobacco, target weight or below
Applicant Would Pay	According to table below for **75% Level of Premium Assistance**	According to table below for **70% Level of Premium Assistance**	According to table below for **50% Level of Premium Assistance**	According to table below for **30% Level of Premium Assistance**

75% Level of Premium Assistance - Applicant Pays

	Target Weight or Below		Above Target Weight	
	Non Tobacco	Tobacco	Non Tobacco	Tobacco
Age	User	User	User	User
<30	$117	$188	$169	$247
30-39	$136	$217	$197	$288
40-49	$165	$264	$238	$348
50-59	$197	$315	$284	$415
60-64	$232	$371	$335	$489
65+	$274	$439	$396	$578

70% Level of Premium Assistance - Applicant Pays

	Target Weight or Below		Above Target Weight	
	Non Tobacco	Tobacco	Non Tobacco	Tobacco
Age	User	User	User	User
<30	$140	$211	$192	$270
30-39	$163	$244	$224	$315
40-49	$198	$297	$271	$381
50-59	$236	$354	$323	$454
60-64	$278	$417	$381	$535
65+	$328	$493	$450	$632

50% Level of Premium Assistance - Applicant Pays

	Target Weight or Below		Above Target Weight	
	Non Tobacco	Tobacco	Non Tobacco	Tobacco
Age	User	User	User	User
<30	$234	$305	$286	$364
30-39	$272	$353	$333	$424
40-49	$330	$429	$403	$513
50-59	$393	$511	$480	$611
60-64	$464	$603	$567	$721
65+	$547	$712	$669	$851

30% Level of Premium Assistance - Applicant Pays

	Target Weight or Below		Above Target Weight	
	Non Tobacco	Tobacco	Non Tobacco	Tobacco
Age	User	User	User	User
<30	$328	$399	$380	$458
30-39	$380	$461	$441	$532
40-49	$462	$561	$535	$645
50-59	$550	$668	$637	$768
60-64	$650	$789	$753	$907
65+	$766	$931	$888	$1,070

Section 4: Eligibility- how do I show that I am eligible for AccessTN?

We will begin by enrolling for two eligibility categories:

A. "AccessTN" – this is the regular category that most will use, including many who were on TennCare.

   You can find the premium rates for this category beginning on page 6 of this booklet. Plans 1000, 2500, and 5000 for this category all have a 6 month waiting period before we pay claims on any medical conditions you had at the time you enroll, called "pre-existing conditions." All plans also have a 12 month waiting period for maternity coverage. Everyone who qualifies for this category must have been without other health insurance for 6 months prior to AccessTN.

B. "TennCare Portability" – this special category is only for someone who purchased a HIPAA plan after being disenrolled from TennCare.

   Rates for Plans 1000, 2500, and 5000 for this category begin on page 8 of these instructions. This eligibility category is only available to those who apply before April 30, 2007, the first 60 days the Plan is taking applications. You do not need to have been without insurance for 6 months for this eligibility category. The rates for this category are higher, but are not subject to any waiting period for pre-existing conditions. However, all plans for this TennCare Portability category still have a 12 month waiting period for maternity coverage.

The additional rules for regular AccessTN and for TennCare Portability are listed in the application, including that you must be a U.S. citizen. For either category, you will also need to send 2 kinds of proof where you have lived in Tennessee for the last six months. This proof can be copies of your driver's license, your lease, or your utility bills, or other documents listed at www.AccessTN.gov.

Section 5: How do I qualify as "uninsurable"?

We are here to offer health coverage to those who can't get other insurance. You must show that you are uninsurable to qualify for <u>either</u> the regular AccessTN category or the special TennCare Portability category. Even if you were in an "Uninsurable" category of TennCare, you must qualify according to our Plan guidelines. You can do this 1 of 3 ways listed below. Use only one.

1. Denial of Coverage Due to Health Reasons by 2 Health Insurers.
2. Medical Underwriting by AccessTN (requires an extra fee of $75.00)
3. Diagnosed with One or More of the Medical Conditions listed in the application on page 3

The application has more information on how to use these options.

Section 6: Other Insurance Coverage

AccessTN requires that you give complete insurance coverage information. AccessTN may return incomplete applications. We will use it to see if you meet our eligibility requirements.

AccessTN is insurance for those who cannot get health coverage elsewhere. We cannot cover those who are able to get other coverage, such as through an employer or spouse's employer. Plan rules require that you let us know if you have other coverage or are able to get other coverage after you qualify for AccessTN.

Section 7: Health History

This information will help AccessTN plan for your health care. Please provide answers to the questions listed on pages 5 and 6 of the application. A five year time period and more medical conditions are listed to help identify more of your needs for care management. You can make copies of the form or use a blank page if additional pages are needed. **You must print your name, sign and date any pages used in addition to the application.**

Section 8: Protected Health Information

Protected Health Information (PHI) means facts and records about your health. This information may include:

- claims records
- correspondence
- medical records
- billing statements
- diagnostic imaging reports
- laboratory reports
- dental records
- hospital records (including nursing records and progress notes)
- your address and date of birth

Federal and state laws protect the privacy of your health facts. Privacy rules say AccessTN or your health providers can't give others information about you unless you give permission. These rules permit us to use this information for your health care, including AccessTN operations such as eligibility and enrollment**.** When you sign your application, you are giving your authorization for your providers or employers or others you name in the application to provide AccessTN information about you as part of your health plan enrollment. This includes TennCare if you were ever enrolled in TennCare.

Section 9: Statement of Understanding and Affirmation

By signing the application you are stating that you understand and affirm all the information in the application. Please take the time to read this information carefully.

Section 10: Persons, if any, who helped you fill out this application

This section is for the applicant to provide the information required if a friend, family member or advocate helped to complete the application. Legal guardian or conservator information is not required.

Separate optional forms and applications available at www.AccessTN.gov or 1-866-636-0080

Optional Application for State Premium Assistance – for use with Plan 1000

Attending Physicians Statement – for your doctor to use to report diagnosis, medical billing codes, and treatment history on any of the 55 medical conditions listed in Section 5 of the application. You must attach it or a letter with the same information to your application if you are using that way to qualify.

List of Tennessee Individual Health Insurers – Two (2) denial letters from any of these insurers may be used to qualify you as uninsurable. They must be letters from the companies, not from agents.

Supplemental Health History Page – if you need extra pages to complete your health history in Section 7. You can also use regular paper but be sure to sign and date each page and attach.

Some insurance terms we've used (see your Plan Document for more complete information):

"Board" means the AccessTN Board of Directors, the body that the Tennessee State Legislature has made responsible for setting the rules, benefit plans, and premiums for AccessTN.

"Care Management" is all the activities the Plan does to coordinate your health care with you and your medical providers. Sometimes called "case management" or "utilization review" for medical events like going into a hospital, most of these services are done by the Plan Administrator's medical and nursing staff.

"Claims" are the requests for payment sent to AccessTN by doctors and other medical providers for health care they provide to you. We will only pay for "covered services". Payment to network providers is based on fees they have agreed to accept from the Plan.

"Co-insurance" is the portion of the claim you are responsible to pay, usually a percentage, such as 20%. This is listed in your benefit plan. It is sometimes called a "co-payment" if the member pays a set dollar amount, like $20.

"Deductible", such as $1000 or $5000, is the dollar amount a member must pay before the Plan starts paying for covered services. Some services, such as covered prescription medicines, are not subject to the deductible for Plans 1000 and 5000.

"Disease management" is a targeted type of care management to assist you caring for specific medical conditions like diabetes or asthma.

"HIPAA" is the Health Insurance Portability Accountability Act of 1996, which has many rules affecting privacy of personal information and which govern pre-existing conditions provisions of health insurance policies. As we use it with the "TennCare Portability" eligibility category, a HIPAA plan is a certain type of individual health insurance policy for which you can't be turned down if you apply for it in less than 63 days after losing certain other coverage.

"Maximum allowed charge" (MAC) is a set dollar fee that network providers agree to accept in full payment of a covered service they provide to you.

"Medical Underwriting" is an insurance term referring to a requirement of a medical background check to qualify for health coverage. We will do this for those who request it and who pay the $75.00 nonrefundable fee.

"Out-of-pocket maximum" is the maximum amount of your share (deductibles, co-insurance, and co-payments) of claims on covered services in a benefit plan before the Plan starts paying 100% of claims for certain benefits.

"Plan Administrator" is the company that has been selected to administer the daily operation of AccessTN, including enrollment, customer service eligibility verification, claims payment, and care management. BlueCross and Blue Shield of Tennessee, Inc. will be serving as Plan Administrator for AccessTN.

"Plan Document" is the formal description which controls plan benefits, policies and definitions, as approved by the AccessTN Board of Directors.

"Pre-authorization" refers to a Plan rule that certain services, such as hospitalization or surgery, must be pre-approved by the Plan to be fully covered.

"Pre-existing conditions" are those for which you received or had reason to receive medical care or treatment during a six-month period immediately before you enrolled in AccessTN.

"Resident" means a person who is legally domiciled in Tennessee (makes his or her home here). One can be staying in several places, but you can only have one domicile, or legal residence. We ask for 2 forms of proof.

"Network" refers to all the health providers who are contracted with the Plan. Non-contracted providers are referred to as "out-of-network."

"Waiting period" is a set period of time you must wait before a benefit plan pays for services for a particular condition, such as maternity, or a pre-existing condition.

ACCESSTN
COVER TENNESSEE

Application for Health Insurance Coverage
State of Tennessee • Department of Finance and Administration

Return applications to:
BCBST, 801 Pine Street, Chattanooga TN 37402
AccessTN is administered by BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

See www.AccessTN.gov or call 1-866-636-0080 toll-free for help with questions or with this application. **Complete all sections in blue or black ink or type and sign. All signatures must be original. Faxed applications will not be accepted.** You should make a copy of this application and all supporting papers before sending. AccessTN will not return copies. We may request additional information.

Section 1 - Your Applicant Information

Last Name	First Name	MI	Gender ☐ Female ☐ Male	Date of Birth (mm/dd/yy)	Social Security Number

Birth name, if different	County, State and Country of Birth

Home Address (proof required as shown page 10)	City	State	Zip Code

How long have you lived at this address? _____ If less than six months, list prior address

Mailing Address (if different from home address)	City	State	Zip Code

Home Phone, with area code ( )	Work Phone, with area code ( )	What is the best way to contact you? (e.g. cell phone, e-mail- provide address or number)

State of most recent Drivers License and #	Status: ☐ current ☐ expired ☐ suspended/ revoked ☐ never licensed ☐ other _____

TN resident for at least six months? ☐ Yes ☐ No	US Citizen ☐ Yes ☐ No If yes, but not born a US citizen, list date of your citizenship:	Primary language (optional) ☐ English ☐ Spanish ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Racial/ Ethnic Heritage (optional – for Title VI purposes) ☐ Asian or Pacific Islander ☐ Black, Hispanic or non-Hispanic ☐ Native American/Alaskan ☐ White, Hispanic or non-Hispanic ☐ Mixed Ethnicity ☐ Other _____

Number of people in household?	Total family income: ☐ $0 - $15,000 ☐ $15,001 - $30,000 ☐ $30,001 - $45,000 ☐ $45,000 - $60,000 ☐ $60,001 - $75,000 ☐ over $75,000

See the AccessTN instructions booklet for definitions of household, family income, residence, and other terms.

Have you ever been on TennCare? ☐ Yes ☐ No	If yes, did your TennCare end after July 2005? ☐ Yes ☐ No	If yes, when? (mm/dd/yy)

Section 2 - Health Plan

Choose your benefit plan:

☐ $1,000 deductible – Plan 1000
Premium assistance is available for **Plan 1000** only.

☐ $2,500 deductible – Plan 2500
This plan qualifies for a health savings account.

☐ $5,000 deductible – Plan 5000

All coverage begins on the first day of the month as described in Section 9.

Section 3 - Required Premium Information

Height	Weight

Have you used tobacco products during the past 12 months? ☐ Yes ☐ No

You will be billed if approved. You can estimate your premium using the premium tables in the AccessTN instructions booklet.

☐ Check here if you are applying for help with premiums. If so, you must include the separate Premium Assistance Application. Persons with family income of $60,000 or less a year may qualify, if funds are available.

Section 4 - Pick the eligibility category you are applying for

Check either box A or B below to pick your eligibility category (pick only one)

☐	A.	**Regular AccessTN –** this category has lower rates (p.6) and a 6 month pre-existing conditions waiting period. **Note: former TennCare enrollees may qualify for either this category or for TennCare Portability.**

To be eligible to participate in regular AccessTN you must:

- Qualify as uninsurable
- Be a United States Citizen, 19 years old or older
- Be a resident of Tennessee for at least the last six months (you must prove where you have lived)
- Not have access to other health insurance when you apply for AccessTN
- Not have had health insurance within the last six months
- Have used up any continuation coverage (COBRA) if you had group health insurance terminated

☐	B.	**TennCare Portability –** this category has higher rates (p.8) and no pre-existing conditions waiting period**. Note: To qualify for this category, you must have been on a HIPAA plan since TennCare**.

To be eligible for TennCare Portability, you do not have to go without insurance for 6 months.

You must:

- Qualify as uninsurable
- Be a United States Citizen, 19 years old or older
- Have been on a HIPAA plan since you were disenrolled from TennCare (see below)
- Be a Tennessee resident for at least the last six months (you must prove where you have lived)

For Box B you must answer these 3 questions			
	☐ Yes	☐ No	I was in an eligibility category disenrolled from TennCare on August 2005 or after.
	☐ Yes	☐ No	I have been on a HIPAA policy issued by _____.
	☐ Yes	☐ No	There has been no break in coverage since TennCare of 63 days or more.

Section 5 – Check the way you are showing you are uninsurable (choose only 1)

When you have marked Box "A" or "B" in Section 4 above, choose one of the boxes below:

☐	1.	**Denial of Coverage Due to Health Reasons**

Within the last 18 months, you were denied individual health insurance coverage by two different companies due to health reasons. Qualification can be based on ANY health condition. You must attach copies of insurance denial letters. A letter from an insurance agent is not sufficient; it must be an official letter from the insurance company. A list of the insurers is located at www.AccessTN.gov.

☐	2.	**Medical Underwriting by AccessTN (requires a fee to be paid with this application)**

You are asking that we review your health history to see if you qualify for coverage. Qualification can be based upon ANY health condition. This is called medical underwriting and requires a **cashier's check or money order for $75.00, made payable to Fort Dearborn Life Insurance Company**. **This fee is non-refundable** if your health history is sent for underwriting **regardless** of the outcome of underwriting. If you choose this method to qualify, you may also be responsible for getting additional doctor's records at your own expense, as requested. There will be a limited number of applications that may qualify in this way. Those submitted over the available limit will then be asked to qualify using either "1" or "3".

☐	3.	**Diagnosed with One or More of These Medical Conditions (continued on next page)**

This way is based upon specific health conditions. Within the last three years, have you had any diagnosis, treatment, or medical advice relating to any of the medical conditions listed in the box on the next page? You must attach a statement from your doctor, including applicable billing code, date of diagnosis and treatment. A form for your doctor's use is at www.AccessTN.gov. Or your doctor can write us a letter with the required detail. The letter can be sealed if your doctor chooses, but it must be attached to your application or we will return your application to you for completion.

Section 5 – Showing you are uninsurable (continued)

Cancer
- Cancers, excluding skin cancers except melanoma
- Hodgkin's disease
- Leukemia

Circulatory
- Aplastic anemia, chronic
- Arteritis, necrotizing
- Cerebral vascular accident (stroke) other than transient ischemic attack
- Congestive heart failure, including cardiomyopathy
- Embolism, cerebral, pulmonary
- Heart attack (myo-cardial infarction) within 5 years
- Heart bypass surgery within 5 years
- Hemophilia
- Hepatitis B, C, D or G acute or chronic, moderate or severe with medication
- Sickle cell anemia
- Thalassemia with present symptoms

Digestive
- Cirrhosis of the liver
- Crohn's Disease, with current symptoms and requiring surgery
- Pancreatis, chronic
- Ulcerative colitis, present

Endocrine
- Diabetes, type I or type II uncontrolled, or diabetes with complications (eyes, kidneys, feet, etc.)

Major
- AIDS/HIV+
- Transplants, completed or recommended, excluding cornea transplants & donors

Musculoskeletal
- Arthritis, rheumatoid
- Cleft palate, requiring surgery, excluding microform cleft
- Legge-Perthes disease
- Still's disease

Nervous System
- Alzheimer's
- Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- Brain injury, traumatic
- Cerebral palsy, moderate to severe
- Friedrich's ataxia
- Guillain-Barre syndrome, presenting
- Huntington's chorea
- Hydrocephalus
- Lead poisoning (cerebral)
- Multiple sclerosis, post-lateral
- Muscular dystrophy
- Myasthenia gravis
- Paralysis, including quadriplegia & paraplegia
- Parkinson's disease
- Sclerosis
- Sturge-Weber syndrome
- Syringomyelia
- Tabes dorsallis (locomotor ataxia)
- Topectomy and lobotomy
- Tumors, brain or pituitary

Other
- Autistic spectrum disorders
- Cystic fibrosis
- Systemic lupus (lupus erythematosus)
- Wilson's disease

Psychiatric
- Psychotic disorders, including schizo-phrenia and delusional disorders

Respiratory
- Pulmonary emphysema, moderate to severe
- Pulmonary fibrosis
- Silicosis (black lung)

Urinary
- Hypertensive renal disease
- Kidney, chronic renal failure, including receiving dialysis
- Kidney, polycystic

Section 6 - Other Insurance Coverage

AccessTN requires that you complete the following information and may return incomplete applications. The program may use data regarding other insurance or employer based health benefits to review statutory eligibility requirements. AccessTN may also use this data to review its role in the insurance market.

Have you ever been covered by TennCare? ☐ Yes ☐ No If yes, when?
Are you eligible for Medicare? ☐ Yes ☐ No

Are you employed? ☐ Yes ☐ No If no, when were you last employed? If yes, how are you employed? ☐ Full-time ☐ Contract worker ☐ Temporary ☐ Part-time			
Please complete the following for your current or most recent employer			
Name of Employer			
Street Address	City	State	Zip Code

Section 6 – Other Insurance Coverage (continued)

Does this employer offer health insurance? ☐ Yes ☐ No
If yes, are you now or have you ever been covered? ☐ Yes ☐ No

If ever covered by this employer's insurance, what date did that coverage end and why? _____

_____

If never covered under this employer's plan, why? _____
☐ Missed enrollment ☐ Too expensive ☐ No dependent coverage available ☐ Other: _____

If not on current employer's plan, is there a time when you can enroll in the future? ☐ Yes ☐ No
If yes, when can you enroll in the future, if you know? _____

Or, if no, why not? _____

If you are married and your spouse is employed, please complete the following:

Does your spouse's employer offer health insurance? ☐ Yes ☐ No
If yes, are you now or have you ever been covered by your spouse's plan? ☐ Yes ☐ No

If ever covered by spouse's employer insurance, what date did that coverage end and why? _____

_____

If no, why are you not covered under your spouse's plan?
☐ Missed enrollment ☐ Too expensive ☐ No dependent coverage available ☐ Other: _____

Are you eligible for any other health insurance at this time? ☐ Yes ☐ No
If yes, are you planning to apply for that coverage? ☐ Yes ☐ No If yes, what kind? _____

If you have been covered by any insurance program (including Medicare or TennCare) in the last 12 months, please complete the following:

Primary Policy Holder		SSN or ID # of Policyholder
Name of Insurance Company	Policy #	Group #

Beginning Date of Coverage	Ending Date of Coverage	Reason Coverage Ended
Group or Individual Policy ☐ Group ☐ Individual ☐ Do not know		If a Group Policy, provide name of employer

Section 7 - Health History

Please answer the following questions to the best of your knowledge. This will help AccessTN plan for your health care. (A five year time period and more medical conditions are listed to help identify more of your needs for care management.) This health questionnaire can be updated after the application is sent by mailing any changes to **AccessTN, c/o BCBST, 801 Pine Street, Chattanooga TN 37402**. Also, if you pay the separate fee and request that we evaluate your insurability, we will use this health history. But we need your health history either way.

Section 7 - Health History (continued)

Please be sure to complete all questions. Incomplete applications may be returned.

Applicant Name	Date of Birth	Height	Weight

Have you used tobacco products during the past 12 months? ☐ Yes ☐ No ☐ Cigarettes ☐ Chewing tobacco ☐ Pipe ☐ Cigars	How Long?	How Often?

Have you gained or lost more than ten pounds in the last year? ☐ Yes ☐ No	If yes, how much?

If yes, tell the cause of the weight gain if choose to (optional):

In the past five years, have you been evaluated or treated for alcoholism or chemical dependency; or joined any organization for alcoholism or chemical dependency; used illegal drugs; or been advised by a health care professional to reduce the use of alcohol or illegal drugs?	☐ Yes ☐ No
In the past five years, have you sustained an injury as a result of an auto or work-related accident?	☐ Yes ☐ No
In the past five years, have you been treated or diagnosed by a medical professional as having AIDS or AIDS Related Complex (ARC)? We are NOT seeking HIV test results.	☐ Yes ☐ No
Are you currently pregnant? If Yes, please indicate your due date:	☐ Yes ☐ No

Within the past five years, have you been counseled, or consulted a medical provider or received treatment for any of the following? If you answer "yes" to any of the questions below, please list any facts that you remember, such as your doctor's name or date of treatment, on the following page.

1. Heart disease or disorder, such as congestive heart failure, coronary artery disease, previous heart attack, angina, stroke, circulatory disorder, chest pain, high or low blood pressure, anemia or blood disorder, elevated cholesterol and or/triglyceride levels or any other circulatory system issue?	☐ Yes ☐ No
2. Ulcers, stomach disorder, liver/pancreas disorder, hernia, gallbladder disorder, rectal disorder, intestine disorder, esophageal disorder, hepatitis, colitis, Crohn's disease or any other digestive system issue?	☐ Yes ☐ No
3. Urinary tract/kidney/bladder disorder, prostate disorder, renal failure, menstrual disorder, genital disorder, sexual dysfunction, infertility, dialysis, sexually transmitted disease, pregnancy complications (e.g., premature birth, miscarriage, C-Section), breast disorder or other genitourinary system issue?	☐ Yes ☐ No
4. Connective tissue disorder, thyroid disorder, adrenal disorder, diabetes, enlargement of the lymph-nodes, lymph system disorder, pituitary disorder, any growth disorder or other endocrine system issue?	☐ Yes ☐ No
5. Allergy(ies), asthma, chronic obstructive pulmonary disease (COPD), emphysema, sinus or nasal disorder, lung disease or disorder, shortness of breath, sleep apnea or other respiratory system issue?	☐ Yes ☐ No
6. Arthritis, fibromyalgia, back/neck disorder, joint/bone disorder, knee disorder, carpal tunnel, skin disorder, chronic fatigue syndrome or other musculoskeletal issue?	☐ Yes ☐ No
7. Brain disorder, aneurysm, paralysis, central nervous system disorder, cerebral palsy, epilepsy or other seizures, headaches, multiple sclerosis or other nervous system issue?	☐ Yes ☐ No
8. Cancer, tumor, abnormal growth, cyst, or carcinoma-in-situ (cancer localized to cells where it began)?	☐ Yes ☐ No

Section 7 - Health History (continued)

9. Eye or ear disorder?	☐ Yes ☐ No
10. Attention deficit disorder, eating disorder, psychological disorder, suicide attempt, depression, anxiety, autism or other behavioral health issue or biologically based mental illness (schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, panic disorder)?	☐ Yes ☐ No
11. Organ or other type of transplant or implant (including breast implants), gastric bypass, physical deformity or defect including cleft lip or cleft palate, prosthetic device, congenital disorder, down's syndrome?	☐ Yes ☐ No
12. Any other injury, illness or treatment for any condition not already listed; been hospitalized or been scheduled for hospitalization; had surgery or had surgery scheduled; had a test or a test scheduled; or been recommended to have a test or surgery which was not performed for any reason not already mentioned?	☐ Yes ☐ No

If you answered, "yes" to any of questions 1-12 above, or IF YOU HAVE ANY OF THE MEDICAL CONDITIONS LISTED ON PAGE 3, please list it below and provide details. Exact dates are not required. We are not expecting you to provide medical records with this history unless we make a separate request for them. If you want to, you can also mention any significant family health history, such as a condition that runs in the family.

Attach additional pages as needed. You may use a copy of this form or a blank page; however, **you must print your name, sign and date any pages used in addition to this application**.

Question Number	Date(s) of Treatment	Give full details for each question answered "yes", state the condition, duration and degree of recovery. If accident or injury, also indicate if auto or work-related.	Name and address of attending physician or other health care provider (if available)

If you are taking medication or were prescribed or recommended any medication during the period of time related to your answer (for example, "past five years" or "taking now"), please list all of those medications, dosages, and what medical condition is being treated by each medication in the space provided below.

Attach additional pages as needed. You may use a copy of this form or a blank page; however, **you must print your name, sign and date any pages used in addition to this application**.

Name of drug	Condition drug prescribed for (Asthma, etc.)	Dosage & frequency of medication (e.g. 20 mg. twice a day)	Date(s) medication taken (e.g. 2003-August 2005)	Name and address of prescribing provider

Section 8 - Protected Health Information

Protected Health Information (PHI) means facts and records about your health. PHI may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). It also includes facts like your address and date of birth. Federal and state laws protect the privacy of your health facts. Except as allowed by state and federal law for your health care, including medical treatment and AccessTN operations such as eligibility and enrollment, privacy rules say AccessTN or your health providers can't give others information about you unless you give permission**.**

Federal law requires AccessTN to tell you that, if any party to whom AccessTN discloses your personal information shares it with anyone other than another health plan or medical provider, state and federal laws may no longer protect it. However, alcohol and drug abuse records are protected against re-disclosure by federal confidentiality rules (42 CFR, Part 2). Federal law prohibits re-disclosure of alcohol and drug abuse record information without specified written authorization.

By signing this paper, you are giving your authorization for your providers or employers or others you name in this application to provide AccessTN information about you as part of your health plan enrollment. This includes TennCare if you were ever enrolled in TennCare.

Section 9 - Statement of Understanding and Affirmation

I am applying to AccessTennessee (AccessTN) a non-profit entity of the State of Tennessee, for an individual policy of medical, surgical, prescription and hospital insurance. I understand that this health plan will be partially supported by the State of Tennessee and possibly in the future by federal funding. I understand that I do not have to sign this form. However, I understand if I do not complete and sign this form, or if I take back my permission in Section 8 above, AccessTN may deny my eligibility. Incomplete or unsigned forms will be returned. If I submit an Optional Application for State Premium Assistance, it is incorporated by reference in its entirety as an attachment to this application, as are any attached documents. I affirm by my signature below that I have read and understand these provisions, and that my answers on this application are complete and correct to the best of my knowledge. I understand that benefits, premium assistance, and care management guidelines are subject to change for all AccessTN plans by its board of directors (Board). My signature below specifically affirms the following:

1. I AFFIRM THAT THE INFORMATION PROVIDED ON THIS APPLICATION IS CORRECT UPON PENALTY OF CRIMINAL OR CIVIL PROSECUTION. I understand there are penalties for not providing correct information, for allowing someone else to use my benefits, and for other acts of fraud. I understand my duty to inform AccessTN timely about changes in my work, income, or access to other insurance. I understand computer cross-checking with other state or federal agencies may be used to verify my information, and I will cooperate with requests for additional information.
2. I affirm that my employer(s) has not paid and will not pay or reimburse my premiums for AccessTN. I understand that no one except my family or personal friends can assist with payment of my premiums, except according to guidelines set by the Board and which may be changed from time to time. I understand that, apart from premium assistance, there are currently NO restrictions on assistance I may receive from any source for my AccessTN deductibles, coinsurance, and copayments, subject to change by the Board. However, I will disclose any assistance with my AccessTN premiums I receive from any other person or organization, including my medical providers. I know I can check www.AccessTN.gov or call AccessTN at 1-866-636-0080 to get the most current guidelines and member materials.
3. If this application contains material misstatements or omissions, I understand that AccessTN may do any or all of the following within two years from the date the policy was issued:

   a) cancel the agreement as though it was never effective and refund premiums, less any claims paid;
   b) deny benefits under the pre-existing conditions period and recover claims paid; or
   c) take any other action available to it by law.

   This time limit does not apply to fraudulent misstatements. My application is part of any policy issued by AccessTN. I understand the Office of Inspector General (OIG) investigates for fraud in AccessTN. This provision also applies to my on-going duty to timely inform AccessTN about changes in my eligibility for benefits or premium assistance, and I will cooperate with any investigation conducted on behalf of AccessTN.

Section 9 - Statement of Understanding and Affirmation (continued)

4. My signature on this application authorizes disclosure to and use by AccessTN, or its contractors or agents, of information on my health insurance coverage, health insurance applications, medical claims, TennCare or other Medicaid eligibility, and medical record information about myself, for any lawful purpose, including use by AccessTN to:

   a) determine eligibility for coverage;
   b) preauthorize or process claims for benefits;
   c) perform case management, including utilization or quality assurance reviews; or
   d) conduct an audit or investigate allegations of fraud.

5. I am authorizing any physician, health-care provider, hospital, health plan, insurance company, reinsurance company, or any insurance information bureau to disclose my health information to AccessTN, its contractors, agents, or representatives. This authorization includes the disclosure to and use by AccessTN of the following information, if any:

   a) records of alcohol or chemical dependency and my treatment for those conditions;
   b) records of any mental health treatment, excluding psychotherapy notes;
   c) records of my treatment for AIDS/HIV;
   d) records of genetic testing regarding any medical condition listed on this application IF I am using that genetic condition as a basis for medical eligibility or for care management of that condition.

   AccessTN contractors specifically include Fort Dearborn Life Insurance Company if I request underwriting by AccessTN and Patient Services Inc. if I am requesting premium assistance.

6. This authorization takes effect on the date I sign this application and remains in effect for twelve (12) months thereafter, and if I am enrolled in AccessTN, for the duration of my AccessTN coverage, plus twelve (12) months, or for the duration of any medical claim, whichever is longer. A photocopy of this authorization is as valid as the original. I understand I may request a copy of my authorization pages. I may cancel this authorization at any time by sending a written request to AccessTN. My cancellation of this authorization will not affect any action AccessTN took before it received my request, and will not affect its use of my PHI for AccessTN health care operations. If I do not revoke this authorization, it will automatically expire twelve (12) months after termination of my coverage with AccessTN unless I have a claim pending as above.

7. Unless I am enrolled in the TennCare Portability category, pre-existing conditions will not be covered until the AccessTN policy has been in effect for six months, unless an authorized representative of AccessTN specifically notifies me in writing that it has waived the pre-existing conditions limitation period regarding a specific condition or treatment for a specific time period. A pre-existing condition includes any condition which, during a period immediately preceding the effective date of my coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care, or treatment was recommended or received as to such condition. This pre-existing conditions exclusion does not currently affect outpatient pharmacy or outpatient psychological counseling for any AccessTN category.

8. I understand and agree, if I am granted AccessTN coverage, that, as approved by its Board and as permitted by law, AccessTN may vary deductibles, coinsurance, or treatment levels of its health plans for medical conditions according to criteria which it may establish, by severity of condition, by enrollee category or enrollee income level, or by other reasonable criteria. I understand and agree that AccessTN may vary benefit level according to clinical criteria, by level of enrollee compliance with AccessTN care management, health incentives, or by other Plan guidelines. I agree to cooperate with and adhere to AccessTN health promotion and disease prevention, including specifically AccessTN care management guidelines as periodically established by the Board. I agree that if I fail to comply with AccessTN care management guidelines, my AccessTN coverage may be affected, including but not limited to reduction or elimination of any incentive discount or premium assistance I may be receiving, and including reduction of my insurance coverage. I agree that for this and all purposes related to my coverage, written notice mailed to my most recent address of record with AccessTN counts as notice to me, according to guidelines established by the Board.

9. I understand that my coverage will become effective on the first day of the month, based on the notice of the Plan Administrator that I have been approved. I understand that no coverage will be in effect until my application has been approved by AccessTN and the full correct initial premium is paid and processed, according to AccessTN policies and procedures. If I am not approved for coverage or if I do not pay my premium, AccessTN shall have no obligation to insure me.

Section 9 - Statement of Understanding and Affirmation (continued)

10. For each successive month of coverage, I understand that my premium must be received by the Plan Administrator on or before the due date. If I arrange for automatic payment by bank draft or by credit or debit charge, such transaction will be made according to the schedule provided by the Plan Administrator, and may be before the due date. I shall have a grace period of thirty-one (31) days from the due date, inclusive. However, I understand that my benefit eligibility may be suspended beginning the 1st of any month if the Plan Administrator has not received and credited collected funds to my AccessTN account by the due date, and shall remain suspended during my grace period until such funds are received and processed. I understand that my coverage will be terminated at the end of the thirty-one (31) day grace period if my payment has not been received, or if my check or other payment is disallowed by my financial institution without such payment funds being collected by the Plan Administrator. Any payments or termination, including a waiting period to reapply for coverage, shall be subject to the policies of AccessTN. Notice by U.S. mail to my address of record with AccessTN shall constitute notice to me. I understand that my 31 day grace period does not begin on the date I receive notice, but shall begin according to the above schedule as set by AccessTN.
11. AccessTN will not discriminate against any individual or group because of race, sex, religion, color, national or ethnic origin, age, disability, or military service. Applicants and AccessTN participants may file written complaints regarding discrimination by writing to AccessTN, Division of Insurance Administration, 26th Floor WRS Tennessee Tower, Nashville, TN 37243-0295.
12. AccessTN has procedures under which applicants and members may have grievances reviewed. Applicants may file complaints and grievances related to the AccessTN application procedure by writing to AccessTN, Division of Insurance Administration, 26th Floor WRS Tennessee Tower, Nashville, TN 37243-0295.

Signature applies to this entire application, as described above, and to any attachments.
("Attachments" above specifically includes Optional Application for State Premium Assistance, if any)

Printed name of applicant	Social Security Number
Signature (in ink) of applicant (or legal guardian if applicant is legally incompetent)	Date
If signed by a legal guardian or conservator of the applicant, please print name & address. We may ask for legal documentation.	

Section 10 - Persons, if any, who helped you fill out this application

The applicant is responsible for information in this form and must sign above that all information is true and correct to the best of his or her knowledge.

Applicant must provide the information below if a friend, family member or advocate helped to complete this application. Legal guardian or conservator information is not required by this section.

Name	Organization, if applicable		Phone
Address	City	State	Zip Code
Applicant should sign below ONLY if he or she gives permission for AccessTN to communicate with the person assisting in completing this application about the applicant's information.			
Signature	Date		

Checklist - Please review these before you send in your application to make sure it's complete

☐ Did you fill in completely all the parts of the application that apply to you and sign in blue or black ink under the authorization section (Section 9)? When you mail, make sure to attach enough postage.

☐ Did you remember to provide proof that you are a Tennessee resident? A copy is required of two items that show where you live, and if possible, how long you've lived there. Documents you can use include:

Any documents must show residence address used on this application and your name, or name of your guardian or spouse.

- Current utility bill including telephone, electric, water, gas, cable, etc. (Bill must show date within 60 days - initial deposit receipt is NOT acceptable.)
- Current bank statement (NOT copies of your checks)
- Current rental/mortgage contract fully signed and executed, or receipt including deed of sale for property
- Current employer verification including paycheck stub, work ID or badge, etc. (if shows home address)
- Current automobile, life or health insurance policy (not your wallet cards)
- Current driver license or ID issued by the State of Tennessee to a parent, legal guardian or spouse of applicant (proof of relationship required)
- Current Tennessee motor vehicle registration
- Current Tennessee voter registration
- Current IRS tax reporting W-2 Form
- Receipt for personal property or real estate taxes paid within the last year

☐ Depending on what way you are showing your uninsurability, did you include a doctor's statement or two (2) insurance denial letters? There is a form for your doctor to use, a listing of applicable medical codes, and a listing of insurance companies at www.AccessTN.gov. Your doctor can also write a letter but it must be signed and contain specific diagnosis information, including medical coding (ICD-9 or CPT) details, and attached.

☐ If applying for eligibility through medical underwriting, did you attach a separate cashier's check or money order for $75.00 made payable to Fort Dearborn Life Insurance Company? Remember, this is the only eligibility method that requires a payment to be enclosed with your application.

☐ If you are enrolling in Plan 1000 and want to request premium assistance based on your income, did you complete and sign the Optional Application for Premium Assistance and attach a copy of your most recent tax filing and other documentation of family income?

Faxed applications will not be accepted. Original signatures are required.
Applications may take three to six weeks to process. You will be notified in writing when you are approved or denied for coverage or if you need to submit additional information.

Questions? Please call 1-866-636-0080 or visit www.AccessTN.gov.

Remember: AccessTN does not return copies of your papers. Please make complete copies of this application and all your supporting papers for your records before submitting.
When you mail, make sure to attach enough postage. Mail to:

AccessTN
c/o BlueCross BlueShield of Tennessee, Inc.
801 Pine Street
Chattanooga TN 37402

AccessTN is administered by BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

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Optional Forms

Forms on the following pages are not required for every AccessTN application. They are provided here for your convenience. Please only fill out and attach the forms that fit your situation.

1. Premium Assistance Application

Premium assistance is available for low income AccessTN participants. Fill out this application for AccessTN premium assistance if your household income falls within the following guidelines.

Income Guidelines for Premium Assistance				
Persons in Household	**Federal Poverty Level (FPL)**	**150% FPL**	**200% FPL**	**250% FPL**
1	$10,210	$15,315	$20,420	$25,525
2	$13,690	$20,535	$27,380	$34,225
3	$17,170	$25,755	$34,340	$42,925
4	$20,650	$30,975	$41,300	$51,625
5	$24,130	$36,195	$48,260	up to $60,000
6	$27,610	$41,415	$55,220	up to $60,000
7	$31,090	$46,635	up to $60,000	up to $60,000
8	$34,570	$51,855	up to $60,000	up to $60,000
Premium Assistance	75% non-tobacco at target weight or below	70% non-tobacco at target weight or below	50% non-tobacco at target weight or below	30% non-tobacco at target weight or below
Applicant would pay	25% non-tobacco at target weight or below + variation based on weight and tobacco status; subject to maximum contribution	30% non-tobacco at target weight or below + variation based on weight and tobacco status; subject to maximum contribution	50% non-tobacco at target weight or below + variation based on weight and tobacco status; subject to maximum contribution	70% non-tobacco at target weight or below + variation based on weight and tobacco status; subject to maximum contribution

2. Attending Physician Statement

AccessTN plan participants must demonstrate medical uninsurability through one of three methods. One method is to show diagnosis, treatment, or medical advice in the past 18 months related to one of 55 pre-approved medical conditions. If you are demonstrating medical uninsurability due to one of these 55 conditions, have your doctor fill out the Attending Physician Statement and include it with your application. Alternatively, your doctor can give you a letter to attach to your application.

3. Health History (additional pages)

Use this form if you had insufficient room to complete your health history on pages 6 and 7 of the AccessTN application.

Optional Application for State Premium Assistance

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You may be eligible for premium assistance if your household income (*what the IRS calls "total adjusted gross income") is less than $60,000. Complete this form and send to us to determine if you qualify. The AccessTN premium assistance program will be administered by Patient Services Inc. (PSI). Remember that premium assistance is only available for Plan 1000.

When submitted, this will become part of your AccessTN Application for Health Insurance Coverage. It must be complete and must be signed to be considered.

NOTE: Premium assistance will be offered only as funding is available.

Applicant Name: Last: First: MI:	Date Of Birth:
Street Address:	Gender: ☐ Female ☐ Male
City: State: Zip Code: County:	
Mailing Address if different:	
Home phone number ( ) _____-_____	Work phone number ( ) _____-_____ Cell/Mobile phone number ( ) _____-_____
What phone number and what times are the best to reach you?	
Social Security Number (SSN) of Applicant:	Name and SSN of **Head of Household (if different):**
Primary Language: ☐ English ☐ Spanish ☐ Other _____	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Email Address, if you are willing to correspond with us in this way:	

Information required to calculate premium:	
Do you qualify for the incentive premium rate for weighing the target weight or below for your height? ☐ Yes ☐ No	Height
Have you used tobacco products during the past 12 months? ☐ Yes ☐ No	Weight
You will be billed if approved. You can estimate your premium using the premium tables in the AccessTN booklet.	

Please check the way you picked in your AccessTN application to show you are uninsurable (Section 5)

☐ Denial of coverage by 2 Insurers because of health reasons
☐ Medical Underwriting by Access TN with extra fee
☐ Doctors Statement of Diagnosed Medical Conditions

Optional Application for State Premium Assistance

Number of household members. This includes applicant, spouse, parents and dependents (as defined by federal income tax guidelines)	

Names of other members of household	Age	Relationship to Applicant	Is this person your legal dependent for tax purposes?	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

Liquid assets: this information is required for our reporting but will not affect current premium assistance		
Cash or checking accounts	$	
Savings accounts and/or savings bonds	$	
Stocks, mutual funds (not part of an employer-provided retirement plan)	$	
Total Liquid assets	$	
Do you own your own home?	☐ Yes	☐ No
Do you own other property valued at over $25,000?	☐ Yes	☐ No

FOR PREMIUM ASSISTANCE ONLY

REQUIRED DOCUMENTATION: Check the financial documentation provided and attach copies of each to this application. We recommend you also make a copy of everything you send to us to keep for your own records.

_____ Copies of 2006 Federal Tax Forms as filed with the Internal Revenue Service (must be signed and dated) **OR**

If you have not yet filed your 2006 federal taxes, you can submit proof of your household income by providing the following types of income documentation. Check the income documents you are submitting for all members of your household:

_____ 2 recent consecutive pay stubs
_____ W-2 Form
_____ Form 1099
_____ SSI or SSDI determination letter
_____ Social Security benefit letter
_____ Pension Statements
_____ Proof of alimony received
_____ Proof of alimony paid*

*If you are NOT submitting a copy of your 2006 Federal Tax Form, we will only be able to adjust your gross income for alimony paid. To do so, you must attach a copy of the legal decree showing the amount of alimony and copies of cancelled checks or other proof of payment for the last 2 consecutive months.

Note: You must re-qualify for premium assistance on an annual basis. However, if you experience changes in your financial status (i.e. income, employment, marital, insurance eligibility) anytime during the year, you are required to immediately notify us.

Optional Application for State Premium Assistance

AccessTN has selected Patient Services, Inc. (PSI), a 501(c)(3) charitable organization, to administer the AccessTN premium assistance program. They may contact you for this purpose. PSI is an independent non-profit organization that assists patients with certain specific chronic illnesses and conditions.

BlueCross BlueShield of Tennessee, Inc. is the Plan Administrator of all AccessTN benefit plans. PSI and Blue Cross BlueShield of Tennessee, Inc. are completely independent organizations except that each has contracted to administer separate parts of the AccessTN program and will be cooperating to assist you with their respective services.

Some information requests are repeated from the AccessTN program application to speed processing. This allows us to limit the parts of AccessTN applications operations staff see to do their work.

I affirm that the information provided in this Optional Application for State Premium Assistance is true and accurate. I further understand that if I choose to apply for AccessTN premium assistance, this Optional Application for State Premium Assistance shall be incorporated by reference, in its entirety, into my AccessTN Application for Health Insurance Coverage. By my signature below, I specifically reaffirm Sections 8, "Protected Health Information", and Section 9, "Statement of Understanding and Affirmation" of that document and I agree that those shall apply to all information submitted as part of this Optional Application for State Premium Assistance.

I acknowledge that I have read and fully understand the above and I certify that the foregoing information is true and accurate to the best of my knowledge and belief.

Applicant's Printed Name:

_____	_____	_____
Signature of Applicant	Date	Signature of Legal Guardian if Applicant is Legally Incompetent

This Optional Application for State Premium Assistance should be sent in with your Application for Health Insurance Coverage. Faxed applications will not be accepted. Original signatures are required. **Applications may take three to six weeks to process. You will be notified in writing** when you are approved or denied or if you need to submit additional information.

Questions? Please call 1-866-636-0080 or visit www.AccessTN.gov.

Remember: AccessTN does not return copies of your papers. Please make a complete set of copies of this application and all your supporting papers for your records before submitting. When you mail, make sure to attach enough postage. Mail to:

AccessTN
c/o BlueCross BlueShield of Tennessee, Inc.
801 Pine Street
Chattanooga TN 37402

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Attending Physician's Statement

(includes M.D.& D.O.)

Applicant Name:	Applicant Date of Birth:	Applicant Social Security Number:
How long has the applicant been a patient?		

Presumptive Medical Conditions which may qualify an applicant for AccessTN if they meet all requirements

Within the last three (3) years, has the applicant had ANY diagnosis, treatment, or medical advice relating to any of these medical conditions from your office? Please check boxes that apply and list primary ICD-9 or CPT codes in the right-hand column. A list of approved code ranges is on the second side of this form.

Major	☐ AIDS / HIV+ ☐ Transplants, completed or recommended, excluding donor or cornea transplant	
Cancer	☐ Cancers, excluding skin cancers except melanoma ☐ Hodgkin's Disease ☐ Leukemia	
Circulatory	☐ Aplastic Anemia, chronic ☐ Cerebral Embolism, Pulmonary Embolism ☐ Cerebral Vascular Accident (CVA) [Stroke] other than Transient Ischemic Attack ☐ Congestive Heart Failure, including Cardiomyopathy ☐ Arteritis, necrotizing ☐ Hemophilia ☐ Heart Attack (Myocardial Infarction) within 5 yrs ☐ Heart Bypass Surgery within 5 years ☐ Sickle Cell Anemia ☐ Hepatitis B, C, D, or G acute or chronic, moderate or severe w/ Rx ☐ Thalassemia, with present symptoms	
Digestive	☐ Crohn's Disease, with current symptoms and requiring surgery ☐ Ulcerative Colitis, present ☐ Cirrhosis of the liver ☐ Pancreatis, chronic	
Endocrine	☐ Diabetes, Type I or Type II uncontrolled, or diabetes with complications (eyes, kidneys, feet, etc.)	
Musculo-skeletal	☐ Arthritis, Rheumatoid ☐ Still's Disease ☐ Legge-Perthes Disease ☐ Cleft Palate, requiring surgery, excluding microform cleft	
Nervous System	☐ Alzheimer's ☐ Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) ☐ Brain injury, traumatic ☐ Cerebral Palsy, Moderate to Severe ☐ Friedrich's Ataxia ☐ Guillain-Barre Syndrome, Presenting ☐ Huntington's Chorea ☐ Hydrocephalus ☐ Lead Poisoning (Cerebral) ☐ Syringomyelia ☐ Multiple Sclerosis, Post-lateral Sclerosis ☐ Muscular Dystrophy ☐ Myasthenia Gravis ☐ Parkinson's Disease ☐ Paralysis, including Quadriplegia & Paraplegia ☐ Sturge-Weber syndrome ☐ Tabes Dorsallis (Locomotor Ataxia) ☐ Topectomy & Lobotomy ☐ Tumors, Brain or Pituitary	
Other	☐ Autistic Disorders ☐ Cystic Fibrosis ☐ Wilson's Disease ☐ Systemic Lupus Erythematosus (Lupus Erythematosus)	
Psychiatric	☐ Psychotic Disorders, including Schizophrenia & Delusional Disorders	
Respiratory	☐ Pulmonary Emphysema, moderate to severe ☐ Pulmonary Fibrosis ☐ Silicosis (Black Lung)	
Urinary	☐ Kidney, Polycystic ☐ Hypertensive Renal Disease ☐ Kidney, Chronic Renal Failure, including members receiving dialysis	

Printed Physician Name:	Medical License # :
Office Address:	State of Licensing:
_____ Signature	_____ Date

Note: Please give original copy to Applicant to attach to Application for Insurance Coverage, but please retain a copy, if possible.

Body System	Medical Condition within 3 years	Diagnostic Codes	Procedural Codes
Major	AIDS / HIV+	042, V08, 079.53	
	Transplants, completed or recommended, excluding donor or cornea transplant	996.8 - 996.89, V42.0 - V42.4, V42.6 - V42.9, V49.83	38240, 38241, 38242, 33935, 33945, 44135, 44136, 47135, 47136, 32851, 32852, 32853, 32854, 48160, 48554, 50360, 50365, 50380
Cancer	Cancers, excluding skin cancers except Melanoma	140.0 - 172.9, 174.0 - 208.9,	

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		230.0 - 234.9	
	Hodgkin's Disease	201.0 - 201.9	
	Leukemia	202.4, 204.0 -208.9	
Circulatory	Aplastic Anemia, chronic	284.0 - 284.9	
	Cerebral Embolism, Pulmonary Embolism	434.1, 415.1	
	Cerebral Vascular Accident (CVA) [Stroke] other than Transient Ischemic Attack	430 - 432.9, 433.01, 433.11, 433.21, 433.31, 434.01, 434.11, 434.91, 436	
	Congestive Heart Failure, including Cardiomyopathy	425.0 - 425.9, 428.0 - 428.9	
	Heart Attack (Myocardial Infarction) within 5 yrs.	410.0 - 410.9	
	Heart Bypass Surgery within 5 years	V45.81	33510 - 33542, 33572, 93556
	Hepatitis B, C, D, or G acute or chronic, moderate or severe w/ Rx	070.2 - 070.713	
	Sickle Cell Anemia	282.60 - 282.69	
	Thalassemia, with present symptoms	282.4 - 282.49	
	Arteritis, necrotizing	446	
	Hemophilia	286 - 286.2	
Digestive	Crohn's Disease, with current symptoms and requiring surgery	555.0 - 555.9	
	Ulcerative Colitis, present	556.0 -556.9	
	Cirrhosis of the liver	571.0 - 571.2, 571.5	
	Pancreatis, chronic	577.1	
Endocrine	Diabetes, Type I or Type II uncontrolled, or diabetes with complications (eyes, kidneys, feet, etc.)	250.1 - 250.9	
Musculoskeletal	Arthritis, Rheumatoid	714.0 - 714.4	
	Cleft Palate, requiring surgery, excluding microform cleft	749.0 - 749.04, 749.2 - 749.25	42200 - 42225
	Still's Disease	714.3	
	Legge-Perthes Disease	732.1	
Nervous System	Alzheimer's	331	
	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	335.2	
	Brain injury, traumatic	852, 854 - 854.1	
	Cerebral Palsy, Moderate to Severe	343 - 343.9	
	Friedrich's Ataxia	334	
	Guillain-Barre Syndrome, Presenting	357	
	Huntington's Chorea	333.4	
	Myasthenia Gravis	358.0, 358.01	
	Sturge-Weber syndrome	759.6	
	Tabes Dorsallis (Locomotor Ataxia)	94	
	Hydrocephalus	331.3, 331.4, 741.0, 742.3	
	Lead Poisoning (Cerebral)	984.0 - 984.9	
	Multiple Sclerosis, Post-lateral Sclerosis	340, 335.24	
	Muscular Dystrophy	359 - 359.1	
	Parkinson's Disease	332 - 332.1	
	Paralysis (hemiplegia, quadriplegia, paraplegia)	342 – 342.9, 344.0 – 344.09, 344.1	
	Syringomyelia	336	
	Topectomy & Lobotomy		61323, 61537 - 61540, 61490
	Tumors, Brain or Pituitary	191 - 191.9, 198.3, 194.3, 198.89, 225.0, 227.3, 234.8, 237.0, 237.5, 239.6, 239.7	
Other	Autistic Disorders	299 - 299.9	
	Cystic Fibrosis	277 - 277.09	
	Systemic Lupus Erythematosus (Lupus Erythematosus)	710	
	Wilson's Disease	275.1	
Pyschiatric	Psychotic Disorders, including Schizophrenia & Delusional Disorders	290.8, 290.9, 293,82, 293.9, 294, 294.8, 294.9, 295 - 295.9, 296.34, 296.44, 296.54, 296.64, 297 - 298.9	
Respiratory	Pulmonary Emphysema, moderate to severe	492 - 492.8	
	Pulmonary Fibrosis	515	
	Silicosis (Black Lung)	502	
Urinary	Kidney, Polycystic	753.1, 753.10, 753.12 - 753.14	
	Kidney, Chronic Renal Failure, including members receiving dialysis	585 - 585.9	V45.1, V56 - V56.8
	Hypertensive Renal Disease	403 - 404.9	

Mail to:

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c/o BlueCross BlueShield of Tennessee, Inc.
801 Pine Street
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Health History, Section 7- additional pages
Application for Health Insurance Coverage
State of Tennessee • Department of Finance and Administration
Return with applications to:
BCBST, 801 Pine Street, Chattanooga TN 37402
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AccessTN Application for Health Insurance Coverage
Section 7 - HEALTH HISTORY (continued)

If you answered, "Yes" to any of the questions or conditions in Section 7 of the Health History, please list question # to which you are responding and provide the complete details in the space provided below.

Applicant Name:			**Date of Birth:**
Question Number	Date(s) of Treatment	Give full details for each question answered "Yes", state the condition, duration and degree of recovery. If accident or injury, also indicate if auto or work related.	Name and address of attending physician or other health care provider.

If you are taking medication or were prescribed or recommended any medication during the period of time related to your answer (i.e. past five (5) years or currently taking), please list below all of those medications, dosages, and what medical condition is being treated or were treated by each medication.

Name of drug	Condition drug prescribed for (e.g. asthma)	Dosage & frequency of medication (e.g. 20 mg. twice a day)	Dates medication taken (e.g. 2003-August 2005)	Name and address of prescribing provider

_____ Signature

_____ Date

Call 1-866-636-0080 toll free with questions or for help with these papers